



APPLICATION FOR LAW AND ETHICS EXAMINATION

For Office Use Only

ATS# _____

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Received

No Fee Required

(Please type or print neatly)

1. NAME

LAST

FIRST

MIDDLE

2. ADDRESS OF RECORD

STREET

CITY

STATE

ZIP CODE

3. TELEPHONE NUMBER

EVENING

DAY

4. Do you have a disability or condition that requires special accommodations?

If yes, email "db_examination@dca.ca.gov" for a "REQUEST FOR ACCOMODATION" packet.

5. Preferred Examination

☐

Northern
California

☐

Southern
California

Month

Date

Signature of Applicant

6. CERTIFICATION OF DEAN OF DENTAL COLLEGE GRANTING DEGREE:

(Must be completed or application will be returned)

I HEREBY CERTIFY THAT

Full Name of Student

Matriculated in the

Name of University

Dental College the Day of And attended

Years, has completed the clinic and didactic requirements and

HAS GRADUATED, OR WILL GRADUATE OR IS EXPECTED TO GRADUATE

With the degree of:

Check one

☐ D.D.Sc.

☐ D.D.S.

☐ D.M.D.

On the Day of ,20 .

(SEAL OF
COLLEGE OR
UNIVERSITY)

SIGNATURE OF DEAN